AUSTRALIAN SOCIETY of DENTISTRY for CHILDREN

MEMBER ASSOCIATION OF IAOC

NEWSLETTER

SEPTEMBER. 1986.

The Federal President's Column

September 1986 and all's well! What with countless epitaphs on the fate of Australia's macro economy pouring forth from television and radio, and blotting out the sensible news print, one tends to forget the better things about the lucky country.

It can be recommended to those suffering media toxaemia the benefits gained by switching off to the persuasive linguistics of politicians, rumours of head hunting journalists and the grotesque graphics of the bean counters.

Upon rationalisation of the situation one can return to the beauty of normal and "get on with the job". Australian children are becoming a caries free generation who enjoy visiting their dentist. The majority of children have little or no fear of receiving treatment in the dental surgery.

From a report compiled by Associate Professor Peter Barnard on children's dental health surveys 1979 and 1983, the Australian Bureau of Statistics household figures shew an increase in the number of children who have had a dental consultation (77% to 80%), and in 1983 almost all (98.3%) of 10 - 14 year old children had had a dental consultation. Those who had a dental consultation in the last twelve months (69%) and regular check ups (54% to 60%). Preventive treatment is on the increase and there is a decrease in extractions and fillings.

Take heart, Children's Dentistry is becoming popular. Not only do the patients perceive the difference, but Childrens Dentists are in demand. After all we can do it painlessly and without stress. Australian techniques are among the world's foremost.

Just a final note, on a recent viewing of one of those television news programmes it has become evident that not only can Children's Dentists perform aesthetic dentistry on live patients, but also Cabbage Patch dolls with composite resin teeth are the latest fad.

See you in Adelaide in October.

John Lockwood

President.

Registered by Australia Post —
Publication No. SBG 1719.

6th BIENNIAL CONVENTION - ADELAIDE

October 30th, 31st & Nov. 1st.

LAMINATE VENEERS IN PAEDIATRIC DENTISTRY

(A Synopsis of Quotations by Dr.Richard Jennings, our Guest Lecturer)

The brief quotes noted below have certainly stimulated the thoughts of the Convention Programme Committee, and they are passed on to all members of A.S.D.C to encourage you to attend the Convention and so to hear, in person, Dr. Richard Jennings from Oklahoma, U.S.A..

"There are lecturers in both the U.S.A. and Canada who advocate tooth reduction for all Laminate veneers. I disagree totally with that concept. I have been placing Laminate veneers since 1975, and have yet to touch the tooth with other than phosphoric acid".

So writes Dr. Jennings in correspondence with the Programme Committee. He is a very strong advocate of the use of Laminates in Paediatric Dentistry. Here is a brief history, up to the present day, of Dr. Jennings experience with laminate veneers.

"Back in the dark ages (before 1975) Dr. Faunce and I were etching Tetracycline stained teeth and painting the labial with acrylic resin such as Sevriton or Bonfil. When Composites hit the market we switched to Adaptic.

The advent of U.V. cured Nuvafil gave us a new material and with the setting time under control, we started using both whole and partial crown forms for the composite placement. However, all these techniques and material left questions regarding length of serviceability to the child patient! The first True Laminate Veneers were made by my graduate students at Texas Children's Hospital by an impression of the labial surface, a flasking technique with wax elimination, packing and curing various acrylics. These were truly 'custom made'.

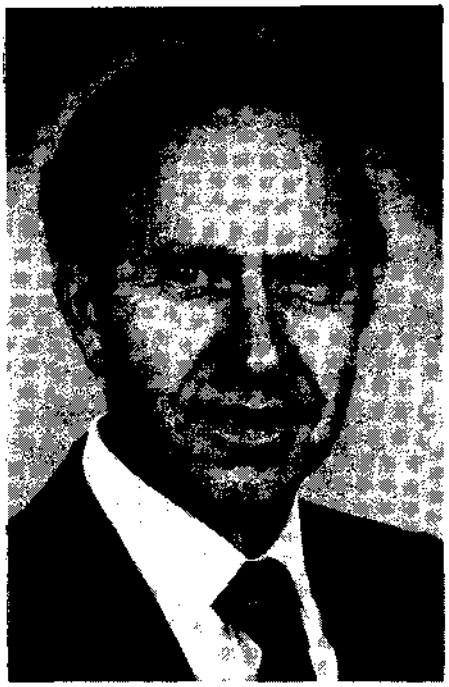
The Caulk Company then picked up the idea and in 1978 marketed pre-formed laminate called Mastique. Mastique still required an impression and some laboratory manipulation to properly fit the labial surface of the tooth. Many companies then jumped into the market resulting in porcelain laminates, vacuum-fired composite laminates, processed acrylic laminates etc.. Porcelain veneers are now becoming very popular in the U.S. but the laboratory cost makes them too expensive in Pedo. At the present time, I am placing custom acrylic Laminates that are .1mm thick. Their use is multifaceted; fractures, large restoration needs, discoloured teeth, to cover unsightly restorations and to close diastemas, all with no tooth reduction.

When Laminates were first introduced in 1977 their acceptance was very slow. I hope to remedy that in Australia and demonstrate to you that there is a place for laminates in today's dental practice".

Now the members of A.S.D.C. will appreciate what the Programme Committee means and why we say "You must come to hear Dr. Richard Jennings, in person". We look forward to seeing you in ADELAIDE in October.

OBITUARY

Dr. DESMOND CRACK



The Victorian Branch sadly reports that Dr. Des.Crack died on July 1st after a short illness.

Dr. Crack was a recent Past President of the Victorian Branch and was widely known and respected by his colleagues throughout Australia.
He was Head of the Department of Children's Dentistry and Special Care Unit of the Royal Dental Hospital of Melbourne and a Senior Clinical Demonstrator in the University of Melbourne.

After receiving his schooling in Brisbane, he graduated from the University of Queensland as a B.D.Sc., in 1958. On graduation he initially worked in general practice and later in the U.K. before returning to take up an appointment at The Royal Dental Hospital of Melbourne. In 1977 he was appointed as the first Head of the Department of Children's Dentistry.

In 1981 Dr. Crack was awarded an M.D.Sc. for his research on the "Dental Needs of the Handicapped and Homebound". This fine seminal study contributed greatly towards the establishment of The Royal Dental Hospital of Melbourne Domiciliary Service for the dental treatment of the Handicapped and Homebound. Not content with this he then developed a unique mobile dental "buggy" so that dental care could be taken easily and efficiently to those in need in the home.

Dr. Crack served the community in many ways. The most notable being as a member of the Armed Forces. After completing National Service he maintained an association with the Army Reserve. He rose to the rank of Major and was O.C. of the 3 Dental Unit Army Reserve at the time of his death.

Dr. Crack was an outstanding clinician, a fine teacher, and above all a humanitarian of the highest order. He is sadly missed by his many friends and colleagues. We extend our depest sympathy to his wife Sally and her family.

The annual A.S.D.C. Victorian Prize to the top Final year undergraduate student in Paediatric Dentistry is to be in future named the "Dr. Des. Crack Memorial Prize in Paediatric Dentistry".

Notes from the Federal Secretary

I have to report that further correspondence has passed between the New Zealand Society of Dentistry for Children and ourselves regarding a closer relationship of our two Societies.

Members will realise that for a merger to be arranged, radical Constitutional changes would be required; you will be given the opportunity to air your views at the General Meeting of A.S.D.C. - to be held on Thursday October 31st, during the Biennial Convention.

My next notice is of a set back - temporary, I hope. Our present Newsletter Editor, Emeritus Professor A.M (Max) Horsnell has given notice that he wishes to retire from this obligation - this year.

The Newsletter has come to hold a Special place in the affairs of our Society, keeping all states informed and in contact. I trust that our Executive can find a worthy successor.

See you in Adelaide!

John Keys

News from the Branches

S.A.Branch

At the June Meeting our Guest Speaker was Dr. Graham Wicks, a well known Adelaide Medical Hypnotherapist, who gave us a most enjoyable and interesting presentation on 'Hypnosis and its Application to Dentistry'.

The history of the medical application of hypnosis was traced and then the advantages of hypnosis over other conventional treatments was discussed. A Video was shewn which demonstrated techniques often use in hypnotherapy for children. Some of the conditions in which hypnotherapy has proved of great benefit were discussed.

In addition Dr. Wicks was able to demonstrate an induction technique, which he uses in practice, on a member of the Society with a high hypnotic capacity.

The evening rekindled an interest in Hypnosis in Children's Dentistry for a numbers of members who had undertaken Hypnotherapy Courses in the past.

In South Australia, at the Adelaide Children's Hospital we have been noticing, with dismay, an increasing number of infants presenting with Nursing Bottle Caries. The children usually require extensive treatment under General anaesthesia. Parents usually claim ignorance as to why their child's teeth have decayed.

SO! with the financial backing of a 'baby-wear' manufacturer (Fluffies Knitwear) we have made a 12 minute Video aimed at Expectant Mothers. Using very simple terms it gives instruction on how to avoid Nursing Bottle Caries.

FLUFFIES are distributing the Video Package free of charge to all Parent Craft classes in South Australia, and later on will do so to such Classes all over Australia.

I now remind members of all Branches of the 6th Biennial Convention in Adelaide, October 30th, 31st and November 1st. Overseas and Interstate people have shewn interest and we in South Australia are looking forward to seeing you in Adelaide.

Vita Luks

The production of this Newsletter has been assisted by Colgate Palmolive Pty. Ltd.

Victorian Branch

The Branch is gearing up for its Ninth Annual Clinical Day on September 10th. The Venue, the Lawn Tennis Association of Victoria, Kooyong and the comprehensive line-up of speakers reflects the theme - "Excellence in Children's Dentistry".

Topics include:

i. "An International Perspective of Excellence in Childrens Dentistry"
ii. "Current trends in Pulp Therapy".
iii. "Plastic Surgery for Children".
iv. "Children's Dental Behaviour - Myths, Magic and Potions".
v. "Adolesodontics; Dental Management of the Adolescent".

Local interest has so far been high and an invitation has been made to ASDC Branches interstate.

The Branch has had one Dinner Meeting, attended by 60 members and guests, since the last Newsletter. Our Guest Speaker was Dr. Gerry Dickenson, a well known Melbourne Orthodontist, who provided a most informative talk on "Orthodontics- Why Treat Early?". Initially, he discussed the philosophy of early treatment and the need for adequate diagnosis.

An outline of Dr. Dickenson's talk is as follows:

Initially, a full history taken of the presenting complaint is essential for proper diagnosis and treatment planning. One must listen carefully to the patient's complaint and then establish a diagnosis which must include the use of radiographs. A prognosis is then established which includes an estimate of the length and type of retention.

Early orthodontic treatment is funda - mentally different to preventive or interceptive orthodontics. When assessing patients with a view to early orthodontic treatment, present and future growth patterns must be assessed, especially in patients prior to pubertal growth spurt.

The clinician must be aware that the face is growing away from the skull in the young child.

Factors in consideration in early orthodontic treatment:

i. Is there stability in early treatment? Often there is not in the long term

cont'd

ii. Is an aesthetic result achievable? 'Yes', at least in the short term.

Early treatment should be

i. Simple
ii. of short duration
iii. Inexpensive
iv. of psychological benefit to the patient

Conditions good for early treatment

1. Functional Problems eg. early correction of crossbites, both anterior and posterior to prevent unwanted functional structures, which otherwise may cause facial asymmetries to develop. With reference to T.M.J. disturbances, it is important that the condyle is kept in the Glenoid fossa. As the height of the Glenoid fossa is not developed until after 12 years, it is important to establish anterior guidance well before age 12.

2. Early treatment in the mixed dentition of Class 11 Div.1 patients may be undertaken to prevent

i. risk of traumatised incisors
ii. incompetent lip seal
iii. psychological problems

Often this can be undertaken by extraction of deciduous canines and an upper removable appliance to retract the upper incisors. This will temporarily improve function and aesthetics, but of course camouflages the underlying problem, which must be treated fully later.

3. Functional Appliances

Functional appliances may be used in the growing patient in selected cases.

Dr. Dickenson then expanded on his talk by relating various treatment options to different craniofacial growth patterns. Individual Case presentations aided by Cephalometric analyses were used to illustrate these points.

The talk was concluded with an extensive question and answer session, reflecting the interest of those present.

Chris Olsen

Queensland Branch

The Branch's Annual Clinic Weekend, Saturday 27th September will take the form of a one-day course presented by Dr. Fred Widdop from Dandenong, Victoria; he will talk on "Teeth and Teenagers" - stressing that this group has special dental needs. His approach will emphasise, use of adhesives eg. Glass ionomers, non invasive solutions to cosmetic problems and simplified and definitive procedures for traumatised teeth. He will also discuss the growth in demand for Orthodontia and discuss Juvenile Peiodontitis.

An open Invitation to sunny, warm Brisbane to attend is issued to any of our interstate visitors.

Contact Bill Whittle -(07)-892 2044 for further information.

At our June Meeting, Mrs. Judy Wilcox, a Nutritionist from the Dietetics Dept. of the Royal Children's Hospital discussed "Nutritional Disorders in Children".

1. She sees the dentist as a key person in a nutrition programme (Preventive Nutrition and Health Education).

   People do need motivation...the dentist should adopt the approach 'not only healthy teeth, but a healthy lifestyle ..' Because motivation tends to be short term it needs constant reinforement. Therefore "teach motivation as broadly as possible so that it touches as many areas of lifestyle as possible"

2. She considers that there are many eating disorders, even in fairly normal families.

   It is important to consider that a balanced diet not only contains nutrition from each of the major food groups, but also the amounts must be in sufficient quantities.

   She sees many malnutrition cases which result from under feeding. She also mentioned, that 'Reflux' is a major cause, as is also feeding the child too much milk. Six months - 1 year is a vital learning period, and in the case of the 'milkoholic', it can be difficult to teach such a child to eat properly. Such children are often deficient in iron, zinc and vitamin B 12. She sees cases of children of

cont'd

   age 3 who are still bottle fed. They may present not only with dental caries but with iron deficiency anaemia and constipation, apart from finicky eaters (no definite meal times, no fruit and vegetables).

3. Diets tend to go through phases of popularity. The question should be posed to the parent: "Have you received advice from a qualified professional?
4. Elimination Diets: It is important to be careful with a child's diet ... ..eg. take out fats and sugars but also insert fruit and vegetables. Also watch the 'locked up calories' in high fibre diets which can leave a child short of calories

Questions to be asked include....

- Is any major food group missing ?
- Is protein being offered 2 or 3 times a day ?
- If the milk group is no being given how is calcium being supplemented ? (Ca sources = sardines, tuna, salmon)
- Is milk not being given for any reason? Milk allergy is very rare. Sometimes lactose in milk cannot be tolerated (not allergy); but it may be able to be absorbed if given in the form of yoghurt or cheese.

5. Many people do not plan on what they feed their children from one meal to the next.
6. Withholding of food as a punishment can be regarded as a form of child abuse.
7. Anorexic states. Many children can induce vomiting at will. This can cause abraisions around the mouth, and often the dentist is the first to note this.
   The average Brisbane child, according to Mrs Wilcox, is under weight - not obese.
8. Obesity in children...object is not to lose weight, but to allow the child to 'Grow into the weight he has'.
9. Finegold Diet. There is much clinical evidence, especially in preschoolers, that a diet high in refined sugars can cause problems. But this diet must be appropriately handled. Also it always pays to remember that what we call 'hyperactive' may not be what parent calls 'hyperactive'.
   Some of these children may be suffering anxiety states, mirroring the parents' problems.

cont'd from p.6

10. Child Diabetic - has been a change of approach, eg. carbohydrate in diet can be as high as the child wants it. The type of carbohydrate is important eg. - more complex.

Incident of Practice

Dr. Bill Whittle presented slides of severe hypersensitivity to Septrim.

From our August meeting

Dr. Peter Smith, of the Haemotology and Oncology Departments, the Royal Childrens Hospital, addressed our meeting on "Childhood Cancer".

He stated that between 1950 and 1978, U.S.A. figures reveal a 46% decline in the incidence of cancer in young age groups, but stressed that while such a decline was evident in younger people this was not so in older age groups.

One in 600 children will develop cancer by the age of 15 and 25% of these will be Leukaemia, thus childhood Leukaemia ia the most common form of cancer in children The Acute Lymphocytic type accounts for 90% of all Childhood Leukaemias.

The most important prognostic feature of Childhood Leukaemia is the initial total W.C.C.(white cell count). Children with high W.C.C. do poorly, while those with low W.C.C. will do well.

Aim of treatment is to get the child into 'Remission'. He stressed that it was essential that the child be maintained in this Remission phase. 'Remission' is not 'cure' and if the child is not maintained in this phase death usually occurs in 6 - 8 weeks.

Chemotherapy is the front-line treatment for children. If this fails then Bone Marrow transplant should be considered. Metastatic disease remains the major problem with Leukaemia but this is mainly controlled by Chemotherapy.

If the C.N.S. is attacked, then cranial radiotherapy has to be carried out. This, in itself, causes long-term problems eg. Brain tumours, Growth problems.

Long term effects of the very severe Chemotherapy agents remains to be fully assessed, but severe effects on the reproductive system are possible.

If a child can be kept in 'Remission' for 5 - 6 years this can be regarded as a cure, because death rates then approximate those for the general population.

Dental treatment.
Because of the increasing success story of drug therapy, dentists can expect to see more of these patients turning up in their practices. He stressed that there was no reason to compromise the quality of life for these cases. But, prior to dental treatment a child on maintenance therapy should have a blood count done. The W.B.C. and Platelet count should be normal for safe dentistry.

Hw also mentioned other tumours ---- the next most common type in childhood is Wilm's Tumour which affects the Kidneys. The cure rate here is 70%.

Tumours of the jaw are very rare and he instanced and showed slides of some of these cases.

He stated that where radiotherapy is required - if the cranium is irradiated to control CNS involvement in Leukaemia, the teeth will not be affected; but this is not the case when tumours of the jaws have to be so treated.

Incidents of Practice.

Dr.Laurie Bourke presented some interesting slides of some cases he treated during his Master's Course.

1. Ectodermal Dysplasia - he treated a case of Anodontia successfully with FU/FL dentures.
2. A case of Malformed Teeth - treated via construction of a partial denture.
3. Dentino-Genesis Imperfecta - use of an overdenture to counteract the severe attrition.

Bill Whittle

Tasmanian Branch

The Branch held its June Meeting at the Launceston Country Club Casino. Our Guest Speaker was Mrs. Pam Goldschmeid and her Topic the "Fringe Benefits Tax".

Mrs Gpldschmeid discussed the Tax from an accountant's point of view and dealt with its implications for the Salaried dentist, the Self-employed dentist and their employees.

There was a great deal of interest in all that the speaker had to tell us and good discussion with a number of questions followed.

Later, a general 'dental' discussion followed with a variety of aspects and Techniques being touched upon, including Bonding and Veneers, and Othodontia.

Our October Meeting will be held at Quigley's Restaurant, Launceston on October 4th, when the Panel Discussion, originally planned for the June Meeting, will take place; the Topic will be "Removable Appliances" and will be followed by wire bending exercises to test members digital competance.

David Abbott

W.A.Branch

At our recent Meeting, 18th June, our Guest Speaker was John Houlton, who is doubly-qualified, in dentistry and Psychology; his Topic for the occasion was"Pain in Dentistry".

He commenced by drawing attention to the fact that one in ten Australians (eg, 1.6 million) are dental phobics! However the experience of pain does have some positive benefits eg. as a warning signal, as a factor in our learning process, as a motivator, and as an essential factor in our survival.

The 'Gate Theory' of Melzack and Wall was described, including consideration of the components of the pain experience and the interaction between these components.

W.A. cont'd

The Psychological Factors were considered under three headings

1. Cognitive factors - for instance the use of the word 'pain' or other similar language will lower the pain threshold. The pain threshold can be raised, conversely, by suggesting to the patient the L.A. is better than previously.
   Meditation, self hypnosis and diversion of attention away from the pain belong to this group.
2. Emotional factors - in this area patient anxiety, depression anger, passive aggression and vigilance (where the patient is in a constant state of arousal and preparation for unpredictable noxious events.)
3. Symbolic factors - this includes ethnic variation; the type of personal image one wishes to convey eg. Martyr or Stoic; the terms of description of the pain (eg. shooting, stabbing) which indicate physical or external assault; cultural and religious influences. John also mentioned the situation of the pain - in wartime, extensive tissue damage didn't always cause severe pain. Soldiers obviously saw their injuries as an escape from the battlefield.

The point was made that pain in dental treatment may be learned by personal experience or by hearing others' experiences. This then establishes a belief that pain will be experienced, and so it proves to be - the prophecy becomes self-fulfilling
The enormous number and variety of factors can all play a part, and the dentist is obliged to be aware of these factors if he is to understand the patient's reactions and to have management strategies for these reactions at the ready.

Alistair Devlin

N.S.W. Branch

The Branch held a very interesting Meeting in July, with 35 members and guests present to listen to Dr. Keith Powell speak on "Space changes in the presence of carious primary molars".

Dr. Powell described the background to a study of Australian Aboriginals and White schoolchildren who suffered from a large backlog of unmet treatment needs in an isolated community. The aim of the Study had two parts.

1. to assess the range of space changes that occur in the deciduous molar region when dental caries causes marginal ridge breakdown, and
2. to assess the extent of the space changes in the deciduous molar region over a five year period in a minimal treatment programme.

Dr. Powell discussed baseline comparisons (intact v. marginal ridge breakdown) which suggest that when marginal ridge breakdown occurs the potential for space loss exists but does not inevitably occur.
Space loss after extraction of a tooth is more likely to be greater than space loss due to caries.

Space Change Values over all 'Time Intervals' of the were within the range of 'leeway space'.

Degree of space loss detected may only be clinically relevant in cases where some orthodontic treatment might be contemplated in the mixed dentition or where space loss exceeded the magnitude of the 'leeway space'.

The interest of those present was shewn very clearly by the lively discussion that followed Dr. Powell's talk.

Our next meeting, September 16th, will be addressed by Professor Keith Lester, Director of Dental Services, Westmead Hospital, and his Topic will be:
"How Enamel Ultrastructure is helping in clarifying the Mammalian Fossil record".

Plans are well under way for a half-day Seminar, and Dinner on Friday 22nd May, 1987 at historic Curzon Hall, to which all members of A.S.D.C. will be invited - more details of the interesting Scientific Programme will follow.

Lorna Mitchell

FROM THE JOURNALS with John Burrow.

BACTERIAL ENDOCARDITIS RESULTING FROM DENTAL TREATMENT.

Bacteraemia following dental procedures may lead to bacterial endocarditis in susceptible patients.Traditional methods of chemoprophylaxis with a parental loading dose of penicillin followed by oral penicillin have proved impractical outside the hospital.In 1979,it was suggested in England that amoxillin be subsituted as the drug of choice in the prophylaxis of bacterial endocarditis.The recommended mode of treatment was a single oral dose of 3g.amoxillin administered 1 hour before onset of the dental treatment.Amoxillin is absorbed to a greater extent and more rapidly than penicillinV It maintains its its effectiveness throughout the critical postoperative period at concentrations well over the minimum necessary to combat Strep.viridans. Amoxicillin has two mechanisms of protection:bactericidal and inhibition of bacterial adherence to the thrombitic vegetation on injured heart valves.

Data obtained from 206 susceptible patients undergoing dental treatment under chemoprophylaxis with amoxicillin showed that in no case did infective endocarditis occur.Only in 13.1% of the patients could very mild side effects of this drug be observed.with this new method, there is a higher incidence of patient compliance and administration is easier to supervise.

(LITTNER M.M. et al Oral Surg.Oral Med. Oral Pathol.61:338-342,1986)

EFFECT OF DUMMY SUCKING ON THE PREVALENCE OF POSTERIOR CROSS*BITE IN THE PERMANENT DENTITION.

According to several studies the prevalence of posterior cross-bite among children and adolescents is 12-25% Atypical swallowing,especially combined with sucking habits,is supposed to influence the development of the transverse relation between the arches.Several authors found a correlation between sucking habits,especially dummy-sucking,and posterior cross-bite in the diciduous dentition.

In 1971 a comprehensive health inspection of all 4-year-olds in the County of Skaraborg was carried out.This also included a dental examination,in which the prevalence of cross-bite was related to the child's sucking habit.The aim of this study was to investigate the development of the transverse relation between the arches in these 4-year-olds up to the age of 16.

Among the 4-year-old dummy suckers,the prevalence of cross-bite was five times as high as that among children with no previous sucking habit.In spite of this fact,it has not been possible in this study to establish a significant correlation between previous dummy-sucking and the development of cross-bite in the permanent dention.

(LARSSON E. Swed Dent J.10:97-101.1986)

PERIORAL INFECTIONS IN CHILDREN.

Dentists occasionally encounter perioral inflammatory conditions in young patients that are difficult to diagnose. These conditions usually are infectious and may create hazards of spread for the patient and clinician.The four reported cases illustrate some diagnostic and patient management problems of perioral infections.

A 6-year-old had crusting lesions of the facial skin,vermillion border of the lips and subsequent spread involved the skin of the face but not the mucous membranes. The condition was diagnosed as GroupA streptococcal pyoderma(impetigo)

A 4-year-old had clusters of small blisters,some crusting lesions involving the skin of the nose,chin,and vermillion of the lips,small ulcers involving the nasal and oral mucous membranes,and gingivitis of the anterior teeth.The diagnosis was primary herpes simplex infection.

A 3-year-old had an irregular erythematous area covered by a thin crust extending from the angle of the mouth onto the skin of the face.Diagnosis was staph.pyoderme

A 5-year-old had areas of erytheme involving the skin of the face of several weeks duration;some of the lesions consisted of elevated,scaly and eroded areas. The lips were swollen.Diagnosis was mucocutaneous candidiasis(immunodeficiency was ruled out)

Pyoderma in the facial region can become serious if the infection spreads into the deeper tissues.Streptococcal pyoderma sometimes can lead to glomerulonephritits,and should be diagnosed and treated as quickly as possible.

Candidal infections of the perioral tissues can indicate immunologic deficiencies and require careful diagnosis.

(WOOLEY,L.H. J Oregon Dent Assoc. 55(1):16-17.1985)

ELEVENTH CONGRESS
INTERNATIONAL ASSOCIATION OF DENTISTRY FOR CHILDREN

TORONTO, CANADA – JUNE 7-11, 1987
THE TORONTO HILTON HARBOUR CASTLE

General Chairman
Franklin Pulver
Treasurer
Beverly Richardson
Executive Secretary
Ilse Erwig

Scientific Programme
Arlington Dungy, Chairman
Gerald Z. Wright
Funds
Roderick Moran
Norman Levine
Melvin Charendoff
Publicity
Marvin Klotz
Publications
David Kenny
Keith Titley
Registration
Keith Titley
Michael Sigal
Trade Exhibits
John Bradey
Keith Morley
Local Arrangements
Franklin Young, Chairman
Julian Geller
Douglas Johnston
Ian MacIntosh
Gregory Mason
Howard McIsaac
Howard Stein

As General Chairman, I would like to invite everyone to the Eleventh Congress of the IADC to be held at the Harbour Castle Hilton Hotel in Toronto, June 7th-11th 1987

Toronto is the largest city in Canada. Its international airport is easily accessible to the world. Our two airlines - Air Canada and Canadian Pacific, service the entire world.

Toronto has a very cosmospolitan population. The temperature average in June is approximately 20° C. You may walk safely in any part of our city.

At the time of writing the Canadian Dollar is 7o% of the United States Dollar and roughly equivalent to the Australian Dollar.

We have a very vibrant waterfront area on the shore of Lake Ontario where the Convention Hotel is located. Close by we have built "Ontario Place" - on three man-made islands - this will be the location of a Reception and Dinner on Monday June 8th.

In addition a movie from the Smithsonian Institute in Washington D.C. called, "The Dream is Alive" will be shown in a private screening on a giant six story screen in the cinesphere of Ontario Place.

FRANKLIN PULVER
(General Chairman of Congress)

Secretariat
Faculty of Dentistry
University of Toronto
124 Edward Street
Toronto, Ontario
Canada M5G 1G6

PH: (416) 979-4313
TX: 06-218915 UT ENG TOR

11TH CONGRESS OF THE INTERNATIONAL ASSOCIATION OF DENTISTRY FOR CHILDREN

TORONTO ONTARIO CANADA

AT THE
HARBOUR CASTLE HILTON HOTEL

Information should be required to:

Secretariat
11th Congress I.A.D.C.
Department of Paedodontics
Faculty of Dentistry
University of Toronto
124 Edward Street
Toronto Ontario
CANADA M5G 1G6

SCIENTIFIC PROGRAMME

- Guest Lecturers
- Free Papers
- Poster Session
- Table Clinics
- Video & Films

Simultaneous translation:

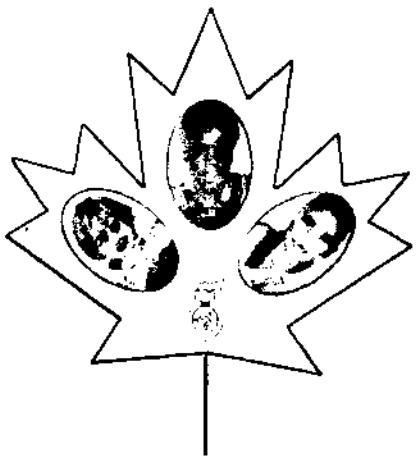
In English, French, Japanese & Spanish (if numbers warrant)

SOCIAL PROGRAMME

- Reception
- Dinner Dance
- Tours of City

Accompanying persons:

A programme is being arranged that may include such highlights as Toronto's famous Science Centre, Ontario Place and a trip to nearby Niagara Falls



JUNE, 7 - 11 - 1987